**PSYCHOLOGICAL HEALTH ASSOCIATES, PA  
Patient Information Form**

**Please print clearly.**  
Patient Information  
  
First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI.: \_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_  
Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Home Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_  
Work Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_  
E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_  
Employment Status or School Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Parents’ Names (for children) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Patient Illnesses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Patient Medication:  
(if needed, continue on reverse)

Primary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Subscriber or Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Policy ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soc Sec # of Insured (Value Options and CIGNA)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Subscriber's Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_  
Relation of Subscriber to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Secondary Insurance:  
Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Subscriber or Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Policy ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Subscriber's Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Relation of subscriber to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
(Initial as appropriate)  
\_\_\_\_I authorize Psychological Health Associates, PA, to release information to my insurance company.  
\_\_\_\_I authorize the payments of Medical Benefits to Psychological Health Associates, PA.  
\_\_\_\_I authorize the release of information to my (or child’s) physician  
  
Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_  
(Signature of Patient or Parent/ Guardian)